ژورنال کلاب

Relationship of Activity and Social Support to the Functional Health of Older Adults

تهیه کننده و ارائه دهنده: لیلا خامی(دانشجوی ارشد پرستاری سالمندی)

استاد محترم مربوطه: خانم دکتر مطلبی

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عنوان

Relationship of Activity and Social Support to the Functional Health of Older Adults

نکات قوت

- عنوان مقاله منعکس کنندۀ محتوا و متغیرهای آن است
- در عنوان از اختصارات مبهم و کلمات نامأنوس استفاده نشده است
- عنوان مقاله جامع و مانع و گویاست و هیچ ابهامی ندارد
- از به کاربردن کلمات اضافه در عنوان پرهیز شده است
- دارای جذابیت برای جذب مخاطب است
- عنوان به صورت فشرده و در ذهن قابلیت ماندگاری دارد

نکات ضعف: (-)

نویسندگان

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نویسندگان

نکات قوت

- نام نویسندگان بعد از عنوان موضوع ذکر شده است
- مشخصات نویسندگان بعد از نام آنها آورده شده است
- مرتبه های علمی و نویسنده مسئول، مشخص شده است
- آدرس و مشخصات نویسنده مسئول برای پاسخگویی ذکر شده است

نکات ضعف:(-)

چکیده

Objectives. According to J. W. Rowe and R. L. Kahn (1997), successful aging is the combination of low probability of disease, high functioning, and active engagement with life. The purpose of this study was to assess the relationship between active engagement with life and functioning in a convenience sample of community-dwelling adults aged 65 and older.

Methods. In this cross-sectional study, 244 members of an organization for older adults were mailed a survey containing the Activity Checklist and the Social Support Inventory as measures of engagement with life and the SF-12 Health Survey as a measure of functioning.

Results. Hierarchical linear regression showed that maintenance of instrumental, social, and high-demand leisure activities was associated with higher physical health scores and maintenance of low-demand leisure activities was associated with lower physical health scores. Maintenance of low-demand leisure activities was associated with higher mental health scores.

Discussion. If changes in potentially modifiable risk factors such as activity are associated with the beginning of functional decline, early intervention may be possible before disability ensues, thus reducing the risk of disability and ultimately health care costs.

چکیده مقاله

مقدمه:سالمندی موفق ترکیبی از احتمال کم بیماری، عملکرد بالا،و تعامل فعال با زندگی

هدف: بررسی رابطه بین تعامل فعال با زندگی و عملکرد

متد:مطالعه مقطعی برروی ۲۴۴ نفر از سالمندان جامعه بالای ۶۵ سال- ابزار شامل چک لیست فعالیت،پرسشنامه حمایت اجتماعی، و پرسشنامه SF-12 برای بررسی عملکرد

روش آنالیز: رگرسیون خطی

نتایج: حفظ فعالیت با نمرات سلامت جسمی عملکرد ارتباط داردش

بحث:با تغییرات در ریسک فاکتورهای قابل اصلاح بالقوه مثل فعالیت امکان کاهش خطر ناتوانی و در نهایت کاهش هزینه های مراقبتی بهداشتی در سالمندان وجود دارد

چکیده

نکات قوت

- چکیده تصویر روشنی از محتوای مقاله را ترسیم میکند
- هدف و اهمیت کلی و قلمرو تحقیق مشخص شده است
- روش تحقیق و گردآوری داده ها و تجزیه و تحلیل نتایج بیان شده است
- چکیده به صورت کوتاه و خلاصه و جامع به ارائه مطالب پرداخته است
- جامعه و نمونه و روش نمونه گیری بیان شده است
- چکیده خواننده را برای مطالعه متن مقاله ترغیب میکند
- فرمول و علائم ویژه، بیان نشده است
- پژوهشگر به قضاوت شخصی در مورد نتایج تحقیق نپرداخته است

نکات ضعف :

- در چکیده نباید بحث نوشته شودو بجای آن باید نتیجه گیری نوشته شود
- در چکیده نبایستی رفرنس نوشته شود

کلید واژه

نکات قوت: (-)

نکات ضعف: کلید واژه ندارد

بیان مساله

SUCCESSFUL aging has been described as adaptation (Baltes & Baltes, 1990), morbidity compression (Fries, 1980), and high functional, affective, and cognitive status (Garfein & Herzog, 1995). Rowe and Kahn (1997) proposed a model of successful aging comprising three components: avoidance of disability, maintenance of physical functioning, and active engagement with life. Successful aging occurs at their intersection and is more than the absence of disease and maintenance of high functioning. Although all three in combination are crucial to living a long and healthy life, active engagement with life has received the least attention.

According to Rowe and Kahn (1997), engagement with life includes activity and social support. Activity has long been a focus of study for researchers interested in successful aging (e.g., Lemon, Bengtson, & Peterson, 1972; Longino & Kart, 1982), and generally activity has positive effects. Researchers have grouped activities into different and often overlapping categories. Engaging in social activities has been associated with increased well being among community-dwelling older adults (Everard, 1999) and among those with arthritis (Zimmer, Hickey, & Searle, 1995). Unger, Johnson, and Marks (1997) found that engagement in social activities was associated with increased physical function and predicted a slower decline in functional status over a 6-year period. Instrumental activities (sometimes called productive activities), such as housework or shopping, also have been associated with better health and function (Glass, Seeman, Herzog, Kahn, & Berkman, 1995; Horgas, Wilms, & Baltes, 1998).

Leisure activities that are physically demanding have been associated with better function for older adults (Seeman et al., 1995; Simonsick et al., 1993). However, less strenuous leisure activities, such as attending classes or volunteering, also have been associated with better functioning (Berkman et al., 1995; Herzog, Franks, Markus, & Holmberg, 1998) and survival (Glass, Mendes de Leon, Marottoli, & Berkman, 1999) among older adults. Although Rowe and Kahn (1997) concentrated on social and productive activities, Herzog and colleagues (1998) suggested that activities that are neither social nor productive are important for health. Additionally, engaging in a variety of activities may indicate more successful aging (Horgas et al., 1998). We therefore included leisure activities, in addition to social and instrumental activities, in the model of successful aging.

Social support and health have been widely studied, and early epidemiological work found consistent associations between social support and mortality (Berkman & Syme, 1979; House, Robbins, & Metzner, 1982). Recent work has shown that perceived support also relates to mortality (Berkman, Leo-Summers, & Horwitz, 1992; Blumenthal et al., 1987). In their review of 81 studies, Uchino, Cacioppo and Kiecolt-Glaser (1996) found that social support was related to positive effects on the cardiovascular, endocrine, and immune systems.

Social support is commonly divided into instrumental and emotional types (Antonucci, 1990; Cohen & Hoberman, 1983). Berkman (1995) suggested that for support to promote health it must provide a sense of intimacy, which emotional support provides. Among older adults, emotional support has been associated with better physical functioning (Seeman et al., 1995) and reduced mortality risks (Penninx et al., 1997), although instrumental support has been associated with

بیان مساله

- سالمندی موفق: سازگاری ، کاهش عوارض، وضعیت شناختی ، عاطفی، و عملکرد بالا
- از نظر رو و کان سالمندی موفق شامل ۳ جزء
  - ✓ اجتناب از ناتوانی
  - ✓ حفظ عملکرد فیزیکی
  - ✓ تعامل فعال با زندگی
- ترکیب این ۳ مورد برای طول عمر و زندگی سالم مهم هستند
- تعامل فعال با زندگی کمتر مورد توجه قرار گرفته

بررسی متون

براساس مطالعه کان و رو(1997):

- تعامل با زندگی شامل فعالیت و حمایت اجتماعی
- فعالیت دارای اثرات مثبت روی سالمندان
- شرکت در فعالیتهای اجتماعی مرتبط با افزایش رفاه سالمندان

براساس مطالعه جانسون و.....(1997):

- ارتباط تعامل در فعالیتهای اجتماعی با افزایش عملکرد فیزیکی
- ارتباط تعامل در فعالیتهای زندگی با پیش بینی تعویق در کاهش عملکرد به مدت ۶ سال
- ارتباط فعالیت ابزاری (کارهای خانه،خرید و ...) با سلامت عملکردی بالا

ادامه

براساس مطالعه هرزوک و همکاران(1998):

- ارتباط سالمندی موفق و عملکرد سلامتی بهتر با فعالیتهای اوقات فراغت علاوه بر فعالیت های ابزاری و اجتماعی

مطالعه مروری یوچینو و همکاران(1996):

- ارتباط اثرات مثبت حمایت اجتماعی بر روی بیماریهای عروق قلبی، اندوکرین، سیستم ایمنی

مطالعه برکمن(1995):

- تقسیم بندی حمایت اجتماعی به ۲ نوع ابزاری و عاطفی
- ارتباط بیشتر حمایت اجتماعی عاطفی نسبت به حمایت ابزاری با عملکرد فیزیکی بهتر و کاهش ریسک های مرگ و میر در سالمندان

بیان مساله

نکات قوت

- اهمیت و ضرورت انجام تحقیق بیان شده است
- اهداف آن از نظر کاربردی و بنیادی بیان شده است
- سوابق پژوهشی استفاده شده با موضوع در ارتباط مستقیم است
- اهمیت مسئله در حدی هست که نیاز به ارائه مقاله مستقل باشد
- در بیان مسئله روانی و صراحت لازم لحاظ شده است
- پیوند موضوع مقاله با سابقهٔ پژوهشی آن به روشنی ترسیم شده است
- پیشینه تحقیق در تدوین گزاره های تحقیق موثر بوده است
- خواننده می تواند با منابع مرتبط با موضوع از طریق مقاله آشنا شود.

نکات ضعف

- مسئله اصلی مقاله به روشنی بیان نشده است
- حدود و ابعاد و جوانب مسئله به روشنی بیان نشده است

هدف

Few researchers have included both activity and social support when examining the relationship between engagement with life and functioning in older adults, and to our knowledge no studies have included social, instrumental, and leisure activities together. The relationship of activity and social support to functioning can be important in development of early interventions to prevent disability or enhance successful aging. In this study we examined the relationship of engagement, as activity and social support, to functioning in older adults.

هدف

- بررسی تعامل (حمایت اجتماعی و فعالیت) با عملکرد
- مداخلات زودرس برای پیشگیری از ناتوانی وافزایش سالمندی موفق

ضرورت تحقیق

- وجود تحقیقات کمتر که شامل هر دو حمایت اجتماعی و فعالیت و بررسی ارتباط بین سبک زندگی و عملکرد درمیان سالمندان
- عدم وجود مطالعه برای بررسی فعالیتهای اجتماعی و ابزاری و اوقات فراغت باهم

هدف

نکات قوت

- هدف مقاله به روشنی توصیف و تبیین شده است
- هدف مقاله متناسب با بیان مسئله تدوین شده است
- خواننده بدون دشواری می تواند هدف مقاله را در متن اصلی بیابد
- در پایان مقاله نویسنده به اهدافی که در مقدمه آمده، رسیده است

نکات ضعف: (-)

متد

Methods

Participants

Participants were a sample of 244 members of OASIS, an organization for older adults. Although a convenience sample, participants were randomly selected to include older adults in health promotion courses, in non-health-related courses, and in no courses. The questionnaire and a stamped, self-addressed envelope were mailed with a cover letter explaining the purpose and that participation was voluntary. Returning the questionnaire indicated informed consent. Reminders were sent to those who had not returned the questionnaire. We mailed 1,007 questionnaires. Twenty-three questionnaires were undeliverable, leaving 984 as our denominator; 697 were returned for a response rate of 71%. A measure of perceived social support was added to the survey midway through data collection. Our analyses were conducted with the 244 participants who completed this and other measures.

جامعه و حجم نمونه

- ۲۴۴ نفر از اعضای سازمان مخصوص سالمندان(OASIS)
- انتخاب بصورت تصادفی از میان سالمندان شرکت کننده در دوره ای ارتقا سلامت، در دوره های غیر بهداشتی مرتبط و هیچ دوره
- ارسال ۱۰۰۷ پرسشنامه همرا یک نامه برای سالمندان
- برگشت ۲۴۴ پرسشنامه با پاسخ کامل

نکات قوت

- شیوهٔ نمونه گیری و دلایل انتخاب این شیوه به روشنی تشریح شده است
- چگونگی تعمیم بخشی نتایج حاصل از نمونه به جامعه تبیین شده است

نکات ضعف

- دلایل انتخاب جامعهٔ پژوهش و ارتباط آن با هدف مقاله ذکر نشده است
- معیار ورود و خروج مطرح نشده است
- جامعهٔ آماری مورد مطالعه و ویژگی های آن به دقت معرفی نشده است

ابزار ها

Measures

We asked demographic questions about age, gender, marital status, education, race, and income. We used a 55-item Activity Checklist modified from the Activity Card Sort (Baum, 1993, 1995) to assess activity engagement. The card sort and the checklist consist of the same activities, and the only difference is in the administration. The checklist describes participants' retention of their activities rather than time committed to activities; activity frequency; and whether activities are done alone, or whether an individual needs assistance with the activity. New activities are noted by participants' indicating that they do the activity now. The Activity Checklist has four subscales: instrumental activities (e.g., shopping, cooking, paying bills, and doing housework), social activities (e.g., traveling, entertaining, attending parties, and attending church), high-demand leisure activities (e.g., swimming, woodworking, walking, and gardening), and low-demand leisure activities (e.g., sewing, reading, watching television, and listening to music). For each activity, participants indicate whether they have never done the activity, have not done the activity within the last 5 years, do the activity now, do the activity less, or have given up the activity.

To calculate current activity, we calculated previous activity levels by totaling the number of activities that participants marked that they do now, do less, or have given up. Each activity they indicated that they do now, do less, or have given up was given a value of 1. Then we calculated activities given up by summing those that participants have given up or that they do less. In this case, activities they have given up were given a value of 1 and those they do less were given a value of .5. We calculated the proportion of activities given up by dividing the activities given up by the previous activity levels. We calculated the current level of activity by subtracting the proportion of activities given up from 1. The scoring procedure was developed to recognize the individual's personal choice of activities and to avoid a penalty for activities never done.

Reliability and validity testing for the Activity Checklist was conducted on a sample of 20 community-dwelling adults aged 65 to 87. We interviewed participants using the Activity Card Sort and mailed them the Activity Checklist after the interview. Participants were mailed another checklist about 30 days after the first checklist was returned. Concurrent validity of the checklist with the Activity Card Sort was .90, .78, .82, and .72 for instrumental, social, low-demand leisure, and high-demand leisure activity subscales, respectively. Test–retest reliability, with a time interval of 74 days, was .95, .83, .91, and .88 for the instrumental, social, low-demand leisure, and high-demand leisure activity subscales, respectively.

ابزارها

Social support.—We used the 17-item Social Support Inventory (SSI) to assess perceived social support because it assesses type (emotional or instrumental) and style (directive or nondirective) of support. Providers of directive support take over responsibility for tasks and are pointed in encouraging "correct" feelings and choices, such as looking on the bright side. Providers of nondirective support cooperate without taking over and accept recipients' feelings and choices.

Participants were asked to indicate on a scale from 1 to 5 how accurately each question described the support they received. We calculated subscale scores by summing the items and dividing by the number of items. Higher scores reflect higher levels of perceived support. Cronbach's alphas were .83, .69, .88, and .93 for directive instrumental, nondirective instrumental, directive emotional, and nondirective emotional support, respectively.

Functioning.—We used the SF-12 Health Survey (Ware, Kosinski, & Keller, 1995) to measure functioning. Its brief subscales, each with six items, assess the effects of physical and mental health on functioning. A performance measure of functioning was not possible in this mailed survey. The subscales were scored using norm-based methods that can be compared to the U.S. population. Scores were transformed into standardized T scores ($M = 50$, $SD = 10$) where higher scores indicate better functioning. Test–retest reliability with a 2-week time interval was .89 for the physical subscale and .76 for the mental subscale (McHorney, Kosinski, & Ware, 1994). Relative validity coefficients, measured with a known groups procedure, for the physical subscale ranged from .43 to .78 and for the mental subscale ranged from .93 to .98 in previous tests (Ware, Kosinski, & Keller, 1996).

آنالیز

Data Analysis

Descriptive statistics were calculated for study variables. To test the relationship between engagement and functioning, we used two hierarchical regression models with the SF-12 subscales as dependent variables. Older, female, and low-income adults often experience poor health. Because others have found effects on the relationship between engagement and functioning, age, gender, income, and marital status were included in the models as controls (Guralnik & Simonsick, 1993). Age was entered in the first step as a continuous variable, as were dichotomous measures of gender (male = 1, female = 0), income (less than $15,000 = 0, at least $15,000 = 1), and marital status (married = 1, not married = 0). Current levels of instrumental, social, high-demand leisure, and low-demand leisure activities and perceived nondirective emotional, nondirective instrumental, directive emotional, and directive instrumental support were entered in the second step. A two-step hierarchical regression model was used because it allows the variables to be added to the equation in the model-defined order (Keppel & Zedeck, 1989). Tests for multicollinearity showed that variance inflation factors ranged from 1.06 to 2.86, well below 10, the cutoff for potential multicollinearity (Myers, 1990). We tested an alternative method using structural equation modeling to take into consideration the relationship between the dependent variables, the only relationship unaccounted for in two separate models. Neither the bivariate correlation between the dependent variables (−.025) nor the path between the dependent variables from the simultaneous model (−.10) was significant. Thus, we chose to use two regression models.

Table 1. Descriptive Statistics for Variables Included in the Regression Models (N = 244)

Variable	*M*	*SD*	Range
Age	73.24	5.29	65–89
Instrumental activities	.86	.12	.33–1.0
Social activities	.78	.17	.18–1.0
High-demand leisure activities	.58	.24	0–1.0
Low-demand leisure activities	.79	.15	.24–1.0
Nondirective emotional support	3.45	1.13	1–5
Nondirective instrumental support	2.65	.68	1–3.7
Directive emotional support	3.14	1.12	1–5
Directive instrumental support	2.07	.89	1–4.8
Physical health	44.59	10.88	16–64
Mental health	54.83	7.36	27–66

Note: Numbers for the activity variables indicate proportions of previous activity levels. The sample was 75% female and 56.6% married; 10.2% had income < $15,000.

ابزار ها

- اطلاعات دموگرافیک
- چک لیست اصلاح شده فعالیت دارای ۵۵ آیتم از روی cart sortفعالیت
- پرسشنامه حمایت اجتماعی (SSI) دارای ۱۷ آیتم
- پرسشنامه عملکرد SF-12

چک لیست فعالیت

- فعالیت ابزاری (خرید، آشپزی، پرداخت قبض ، کارهای خانه)
- فعالیت اجتماعی(مسافرت ، سرگرمی، شرکت در مراسم و جشن، شرکت در کلیسا)
- فعالیت اوقات فراغت با تقاضای بالا(شنا، نجاری ، قدم زدن ، باغبانی)
- فعالیت اوقات فراغت با تقاضای پایین(خیاطی ، خواندن ، تماشای تلویزیون، گوش کردن به موزیک)
- شامل گزینه های (هرگزانجام نداده اند ،در ۵ سال اخیر انجام نداده اند،حالا انجام می دهند ،کمتر انجام می دهند ،فعالیت را ترک کردن) وبرای هر کدام از گزینه ها نمره یک در نظر گرفتند
- انجام روایی و پایایی بر روی ۲۰ نفراز سالمندان در سن ۶۵ - ۸۷

پرسشنامه حمایت اجتماعی (SSI)

- دارای ۱۷ آیتم -ارزیابی نوع(ابزاری- عاطفی) -ارزیابی روش (مستقیم – غیر مستقیم)-نمره آیتم ها از ۱ تا ۵
- پایای با استفاده از الفای کرونباخ

پرسشنامه عملکرد SF-12

- دارای ۶ آیتم
- دارای ۲ زیر مقیاس
  - ✓ سلامت روانی
  - ✓ سلامت فیزیکی
- آزمون مجدد اطمینان

آنالیز

- آمارهای توصیفی
- رگرسیون خطی

ابزار ها و روش تحقیق

نکات قوت

- روش تحقیق به روشنی تبیین و توصیف شده است
- تناسب کارآیی روش مورد استفاده با اهداف پژوهش ذکر شده است
- ابزار گردآوری داده ها و روش تحلیل آنها به روشنی معرفی شده اند
- متغیر های مورد استفاده در تحقیق تعریف شده اند

نکات ضعف:

- دلایل انتخاب روش مورد استفاده ذکر نشده است
- دلایل عدم انتخاب سایر روشهای مشابه ذکر نشده است
- مزایا و معایب ابزار بکارگرفته شده به دقت تشریح نشده است
- نمونه هایی از کاربرد این ابزار در سایر پژوهش ها ذکر نشده است

نتیجه گیری

Results

Participant Characteristics

Participants were primarily White (97.5%) and female (75%). Mean age was 73 (SD = 5.3, range = 65–89), and 56.6% were married. Participants were well educated, with 45% being college graduates. Table 1 provides means, standard deviations, ranges, and percentages for all variables used in the regression models.

Both regression models testing the relationship of activity and social support to physical and mental health were significant. In the model with physical health as the dependent variable, 30.2% of the variance in physical health was accounted for by the independent variables (p = .0001). The control variables entered in the first step accounted for 4.7% of the variance, and social support and activity variables entered in the second step accounted for an additional 25.5% of the variance. In the full model, gender and the activity variables were significant. Being male was associated with higher physical health scores (β = .16, p = .013). Maintenance of instrumental (β = .19, p = .006), social (β = .30, p = .0001), and high-demand leisure (β = .30, p = .0001) activities was positively associated with physical health. Maintenance of low-demand leisure activities was negatively associated with physical health (β = −.19, p = .015).

In the regression model with mental health as the dependent variable, 18.1% of the variance was accounted for by the independent variables (p = .0001). The controls entered in the first step accounted for 3.4% of the variance. The social support and activity variables entered in the second step accounted for an additional 14.7% of the variance in mental health. Only maintenance of low-demand leisure activities (β = .31, p = .0001), however, was independently associated with increased mental health. The regression summaries for both models are displayed in Table 2.

Table 2. Hierarchical Regression Summaries Showing Associations Between Activity, Social Support, and Functioning ($N = 244$)

	Physical Health				Mental Health			
Variables	*B*	*SE*	β	*p*	*B*	*SE*	β	*p*
Step 1								
Age	−.16	.13	−.08	.231	.13	.10	.09	.167
Gender	3.94	1.57	.16	.013	.43	1.15	.03	.708
Marital status	−1.94	1.56	−.09	.216	1.40	1.14	.10	.221
Income	−2.15	2.24	−.06	.337	1.44	1.64	.06	.380
Step 2								
Instrumental activities	17.27	6.19	.19	.006	−6.87	4.53	−.11	.131
Social activities	19.75	5.12	.30	.0001	4.99	3.75	.11	.185
High-demand leisure activities	13.42	3.30	.30	.0001	−.57	2.42	−.02	.813
Low-demand leisure activities	−14.03	5.74	−.19	.015	15.38	4.20	.31	.0001
Nondirective emotional support	.32	.95	.03	.732	.61	.69	.09	.379
Nondirective instrumental support	2.16	1.48	.14	.146	.81	1.08	.08	.454
Directive emotional support	−.81	.90	−.08	.369	.52	.66	.08	.432
Directive instrumental support	−1.12	.89	−.09	.209	−1.16	.65	−.14	.077

Note: For physical health, $R^2 = .047$ for Step 1 ($p = .035$), $R^2 = .255$ for Step 2 ($p = .0001$), and $R^2 = .302$ for the full model ($p = .0001$). For mental health, $R^2 = .034$ for Step 1 ($p = .115$), $R^2 = .147$ for Step 2 ($p = .0001$), and $R^2 = .181$ for the full model ($p = .0001$).

نتایج

- جدول ۱ آمارهای توصیفی: میانگین سن سالمندان ۷۳-زنان ۷۵%- متاهل ۵۶/۶% - تحصیلات دانشگاهی ۴۵%

- جدول ۲ مدل رگرسیون دارای ۲ مرحله

✓ مرحله ۱:ارتباط جنس مرد با سلامت فیزیکی بالا(B=0/3 –P=0/013)

✓ مرحله ۲: حفظ فعالیتهای ابزاری(B=0/19 – P= 0/006) ،اجتماعی(B=0/3- P=0/0001) و اوقات فراغت با تقاضای بالا(B=0/0 –P=0/0001) با سلامت فیزیکی ارتباط مثبت داشتند و حفظ فعالیت اوقات فراغت با تقاضای پایین (B=-0/19 – P= 0/015)با سلامت فیزیکی ارتباط منفی داشت

✓ تنها حفظ فعالیت اوقات فراغت با تقاضای پایین (B=0.31 – P=0/0001) با سلامت روانی ارتباط مثبت داشت

یافته ها و نتایج

نکات قوت

- نتایج و یافته های پژوهش به روشنی توصیف و تبیین شده اند
- نمودارها و جدول های ارائه شده در بخش نتایج گویا و روشن هستند
- یافته های مقاله هدف های اولیهٔ مقاله را تأمین می کند؟
- پس از توصیف نتایج سهم کافی به تحلیل آنها اختصاص داده شده است.

نکات ضعف: (-)

بحث

Discussion

Engagement with life and functioning were related in our sample of community-dwelling older adults, as suggested by Rowe and Kahn's (1997) model of successful aging. Although the sample is restricted, findings provide some interesting information on the relationships between two constructs of successful aging. Maintenance of high-demand leisure, social, and instrumental activities and male gender were associated with greater physical health, and maintenance of low-demand leisure activities was associated with lower physical health. These findings are similar to those of others who found that social (Unger et al., 1997), physical (Seeman et al., 1995), and instrumental or productive (Glass et al., 1995) activities and male gender (Guralnik & Simonsick, 1993) were important for the health and functioning of older adults.

Examining mental health as a functional outcome indicated different associations. Only maintenance of low-demand leisure activities was associated with better mental health. This finding is similar to those of recent studies that have found associations between less strenuous activities and better functioning (Glass et al., 1999; Herzog et al., 1998). Older adults may require sedentary activities in addition to physical and social activities. Low-demand leisure activities may not relate positively to physical health, but they may be important for successful aging because of their effects on mental health. Low-demand leisure activities may replace work activities after retirement or changes in family demands from earlier in the lifespan. These low-demand activities may also replace more physically demanding activities that are given up because of changes in health and may be a marker for physical decline.

Social support was not associated with functioning in this study. Although both activity and social support are included in engagement with life and have been found effective in studies where they are examined separately, when engagement variables are considered together, activity may be more important for functioning than social support. Activity and social support should be considered together in future studies of successful aging to determine their relationship to functioning.

What we have found in this study are potentially modifiable factors associated with functioning that could enhance successful aging. Although these are cross-sectional data, it is important to identify modifiable risk factors so interventions can be developed to decrease the chance of functional decline (Seeman et al., 1995). Often the first activities to show decline are those unnecessary for survival (Baltes & Baltes, 1990) such as leisure and social activities. These activities can be readily observed and older adults can be made aware of the significance of changes in their activities. If older adults themselves or others notice a decrease in their usual activities, or a replacement of high-demand leisure with low-demand leisure activities, something can be done before the decrease in activity results in functional limitations. Interventions done at early stages may be more successful than those done later in reducing disability and ultimately health care costs (Verbrugge & Jette, 1994).

Although findings from this study provide information relating the engagement and functioning constructs of successful aging, limitations exist. Our sample was a random selection of members of an older adult organization, but it is not representative of the population of community-dwelling

بحث

older adults. Ours was primarily a White, well-educated sample in good health. Our sample may have greater access to programs that offer the opportunity to engage in activities that could affect health. Age was not associated with functioning, and this may be due to the restricted nature and good health of our sample. Participants also reported high income, which has been associated with better health (Guralnik & Simonsick, 1993). Although we controlled for the effects of income on functioning, we had few lower income participants. Even with the shortcomings of this study, if activity engagement is related to functioning in this group, we believe they would be related in the population. Further study of these constructs with representative samples is recommended.

Another limitation of this study is the cross-sectional data that confines us to describing associations. Measures of successful aging should be tracked over time to determine the order of causality. Activity and functioning are associated, but it would be useful to determine causation. With these data we cannot say whether those who engage in activities experience better functioning or whether functioning influences activity levels.

Our limited sample provides additional information about Rowe and Kahn's (1997) model of successful aging showing that engagement and functioning are related among older adults. Maintenance of social, leisure, and instrumental activities was associated with better functioning in terms of both physical and mental health, although low-demand leisure activities may differentially affect health. These findings suggest that activity may be a modifiable factor in successful aging that with early intervention could reduce disability and health care costs.

بحث

- ارتباط مثبت تعامل با زندگی و عملکرد در نمونه انتخاب شده شبیه مدل سالمندی موفق پیشنهاد شده توسط کان وروی
- شبیه بودن یافته این مطالعه با یافته مطالعات دیگر که فعالیتهای فیزیکی، ابزاری ، اجتماعی، فیزیکی،جنس مرد مهم بودن با سلامت و عملکرد سالمندان
- بدست آوردن ارتباط های متفاوت متغییرها با سلامت روان و تنها معنادار بودن حفظ فعالیتهای اوقات فراغت با تقاضای پایین با سلامت روان و شبیه بودن این یافته با مطالعات اخیر در مورد ارتباط فعالیت های با شدت کمتر و عملکرد بهتر در سالمندان

بحث

- عدم ارتباط حمایت اجتماعی با عملکرد(موثر بودن فعالیت اجتماعی و حمایت اجتماعی در مطالعاتی که جداگانه بررسی شده اند)
- پیشنهاد بررسی فعالیت و حمایت اجتماعی باهم در مطالعات آینده
- بدست آوردن اطلاعاتی در مورد فاکتور های قابل اصلاح بالقوه مرتبط با عملکرد برای افزایش سالمندی موفق
- شناسایی فاکتورهای قابل اصلاح و آگاه کردن سالمند و اطرافیان از اهمیت این فاکتور ها برایبه تعویق انداختن روند کاهش عملکرد
- تاثیر مداخلات انجام شده در مراحل اول برای کاهش ناتوانی و هزینه های مراقبت های بهداشتی

محدودیتها و پیشنهادها

- انتخاب تصادفی ازعضو سازمان سالمندان و عدم تعمیم پذیری آن به سالمندان جامعه
- عدم ارتباط سن با عملکرد به علت نمونه آموزش دیده از سلامت بهتر
- درآمد بالای نمونه ها و ارتباط آن با سلامتی بهتر
- مقطعی بودن (پیگیری در طول زمان برای تعیین علل بر روی سالمندی موفق)
- با توجه به نمونه و اطلاعات محدود نمیتوان دقیق گفت که تعامل در فعالیت روی عملکرد بهتر اثر دارد یا بالعکس

بحث ومحدودیت و پیشنهاد

نکات قوت

- تشابهات و تفاوت با مطالعات دیگر مطرح شده است
- محدویت ها ذکر شده است
- راهکارهای برای این محدودیت ذکر شده است
- توصیه برای مطالعه های بعدی مطرح شده است

نکات ضعف:

- در بحث نبایستی رفرنس مطرح شود

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نکات قوت

تشکر و قدردانی مطرح شده است

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رفرنس

نکات مثبت

به تعداد مجاز استفاده شده است

اکثرا از منابع جدید استفاده شده است

نکات منفی :(-)

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با تشکر